BANGS (L.B.)

A PECULIAR ACCIDENT DURING A LITHOLAPAXY.

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Accidents complicating the operation of litholapaxy have been reported from time to time, but they have been usually in relation to the urethra and bladder; or from the breaking of the lithotrite, or the clogging of the jaws of the instrument, or from difficulty in entering the evacuating tubes. But I have never read or heard of an accident whose mechanism was due to the stone itself, and therefore it seems to me that the narration of the following case may be of interest to you.

The patient was a man, aged 56, who came under my observation in December last. He was in general good health until six or seven years ago, when he began to have difficulty in starting the stream of urine and was compelled to empty his bladder frequently, passing considerable urine at each time. These symptoms have become progressively worse ever since that time. For three years past he has been obliged to use the catheter. Only within the past year has there been any pain in the bladder, but this pain has been very severe and paroxysmal, especially during the past few months, and was frequently referred to the glans penis. Sometimes his urine has been bloody. Recently, *i. e.*, just before coming under my observation, he has passed some small crystalline calculi. His urine is alkaline, S. G. 1008, albumen about 6 per cent., sediment contains pus, triple phosphates, and a few blood cells. He passes in the 24 hours over 100 ounces of urine.

At my first examination of his bladder a stone was easily detected. There was not the slightest difficulty in entering the bladder. Indeed, it was a very simple procedure. There was no irritability of the urethra and no special pain was caused by the introduction of instruments. So far as could be determined by the searcher, the stone seemed to be of rather more than medium size. In view of the ease and simplicity of instrumentation, together with the fact that the man had chronic nephritis, it seemed wiser to me to remove the stone by the operation of litholapaxy than by any form of cystotomy.

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On December 7th, the patient was put under ether and the usual preparatory steps for the operation were taken. The lithotrite was easily introduced and a stone one inch and a half in diameter was seized and crushed. The evacuating tube was also introduced in turn, and several fragments with some granular debris pumped out. Reintroduction of the lithotrite for further crushing was found to be impossible. Several attempts were made, but for some reason the instrument would not pass beyond a certain distance. With the finger in the rectum, the beak of the instrument was found to be apparently engaged in the prostate, but beyond that it would not pass. Considerable force—such force as I felt justified in making—was used and resisted, but the resistance seemed to be of an elastic kind. Nevertheless, I did not feel warranted to force or thrust the instrument forward to overcome this resistance of whatever kind it might be, lest damage should result to the surrounding tissues. Instruments of different kinds and with various curves were used, but all attempts met with the same result. They all seemed to reach the prostate and there were prevented from further passage. I persevered for several minutes (say, half hour) or until it seemed evident that nothing introduced by way of the urethra would overcome that resistance, and then decided to open the bladder, remove the stone and explore. Accordingly, a rapid suprapubic cystotomy was made with the usual technique. Not until my finger entered the bladder and searched it carefully did I appreciate the peculiar nature of the obstacle offered to instruments passed by way of the urethra. Nor could any explanation of the difficulty have been obtained without digital or ocular exploration of the viscus. It was found that a moderate amount of median hypertrophy of the prostate existed and a prolongation of the left lobe backward into the bladder, the urethra entering the bladder through this medio-lateral hypertrophy. The lateral projection was soft and flexible, and behind this, thrusting it forward toward the right, was the remaining large fragment of stone, caught between it and the posterior wall of the bladder. It had, after the first washing, fallen behind this prostatic obstruction in such a way as to close the internal orifice of the urethra and completely shut off access to the bladder by way of the urethra. The point of the instruments easily entered the prostatic urethra but immediately impinged upon this *dislocated* (so to speak) wing of the prostatic body which was firmly held by the fragment of stone behind it.

This condition of things would never have been appreciated but for the opening in the bladder and the associated explorations. It seems to me to be worthy of note because of its peculiarity and also because it may have some bearing upon a closer discrimination as to the choice of operation.

The subsequent history of the patient was uneventful. There was no complication during convalescence unless it be that the opening in the bladder was a little longer in healing because of the very large quantity of urine secreted by the kidneys.

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